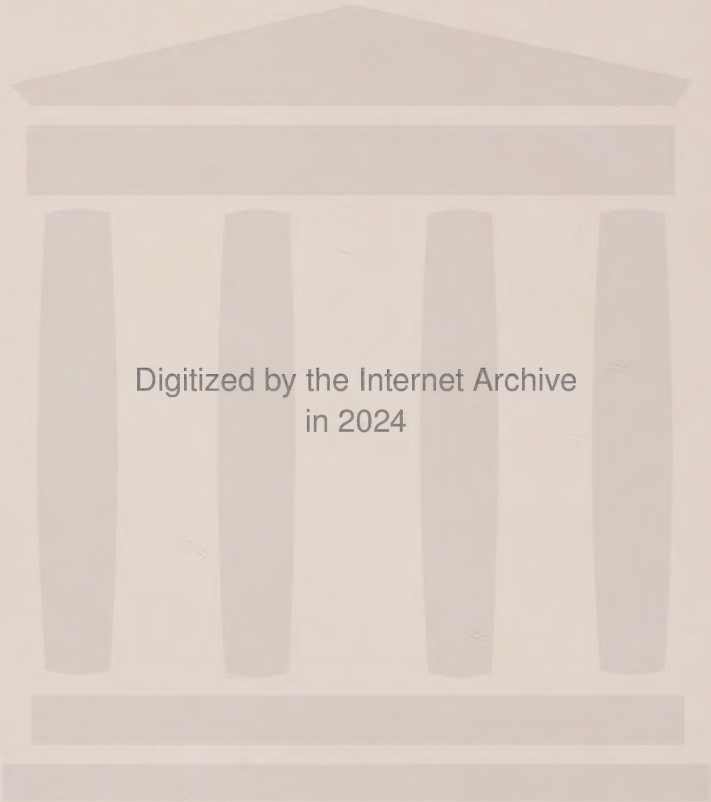
# Practice Management Compendium

## Part 4
## Clinical Practices

John Fry, Kenneth Scott and Pauline Jeffree

Produced as a service to the medical profession by
**E R Squibb**



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## Part 4: Clinical Practices


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# Practice Management Compendium

## Part 1: Understanding the Contract
## Part 2: Organising the Practice
## Part 3: Finance and Reports
## Part 4: Clinical Practices

A Note from the Publisher

This small series of books was launched just after the new contractual arrangements for general practitioners came into force in April 1990.

During the publication of each part there have been changes in the contract and we have tried to incorporate these during the publication process. This is particularly so for Parts 3 and 4 where, for editorial reasons, some of the chapters in Part 3 may, strictly speaking, be more appropriate in Part 4 and vice-versa. Taken as a whole, however, the four parts cover the topics that we set out to address at the beginning of the series and we hope that readers have found the books informative and useful.

# Practice Management Compendium

## Part 4: Clinical Practices

by

**John Fry**

and

**Kenneth Scott**
General Practitioners

and

**Pauline Jeffree**
Practice Nurse,
Beckenham, Kent

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# Foreword

General Practice is undergoing the most major series of changes since the introduction of the National Health Service in 1948. They concern both concepts of care and practical details of the way care is delivered. In spite of the hostility generated by the changes most of the broad general concepts have been accepted. The principle of patients having more choice is widely supported, the inclusion of preventive medicine and anticipatory care in the responsibilities of practice has few opponents, the introduction of audit as a way of improving performance has been generally welcomed. Even the idea of putting GPs in better financial management of patients and drug budgets has had supporters in principle. The antipathy has generally related to the method of introduction of these changes. One important concern has been the time requirements of the New Contract and the feeling that these will erode the real nature of our work: the close personal relationship with patients.

If we improve the quality of our management this is less likely to happen. We shall be able to work within the New Contract and retain the quality of service we provide. If we improve the understanding of our staff of what we are trying to achieve we are more likely to reach the targets that we set whilst keeping people happy.

This book sets out to explain the New Contract. An understanding of this will be essential to those of us who have to work the system, and if we are better informed it will give us more chance of making the sensible amendments that will certainly be needed. I believe it will be a highly valuable source of information for Principals, Trainees and staff in practice and very strongly commend it.

*Professor Sir Michael Drury*
*Head, Department of General Practice*
*University of Birmingham Medical School*

Chapter 1

# Clinical Goals and Challenges

The past 30 years have seen General Practice slowly expand into a Full Primary Care service in small pockets across the country. These changes have been entirely initiated by the doctors and their colleagues in individual practices.

Partnerships of various sizes have emerged with varying levels of support staff. More recent years have seen the introduction of the Practice Manager to oversee practice activity and plan for future development.

The General Practitioner, an independent contractor, is responsible to the Family Practitioner Committee* in the District in which he/she practices, and the practices were funded on standard capitation fees which were weighted for age and indexed item of service payments, e.g., immunisations, cervical cytology, family planning and maternity, which had been negotiated over many years.

* Family Practitioner Committees were replaced by Family Health Service Authorities on the 19th September 1990, the new Authorities being directly responsible to their Regional Health Authorities.

The Practice income was complemented by various subsidiary payments including:

- Group Practice Allowance.
- Basic Practice Allowance.
- Supplementary Capitation fees.
- Vocational training.
- Postgraduate Training Allowance.
- Seniority Payment - funded in three bands starting after 10 years of qualification.

The General Practitioner's income was further increased by fees earned completing Insurance Reports and examinations, private fees, issuing private certificates, medical reports, private patient fees and working outside the Practice including Clinical Assistantships, Industrial Medical Officers and Police Surgeons.

The General Practitioner is responsible for providing general medical services to his/her patients. Supplementary payments are not offered if GPs do not undertake other services for which a target or item of service fee is payable.

With the development of primary care and the employment of more staff both professional and ancillary, many Practices expanded into small businesses.

Practices were not subject to medical audit nor was resource management introduced into primary care services. FPCs had an open-ended budget.

In February 1989 the Government introduced the firm proposals for the New Contract for General Practitioners. The original proposals were subject to discussion with the General Medical Services Committee and the final contract was produced in August 1989 and was incorporated into the new Terms of Service for Doctors in General Practice in November 1989.

The Contract and subsequent changes in terms and services are extensive and encompass all aspects of health care provided by general practitioners and their staff. The object of the changing contract is to:

- Broaden the spectrum of care to all age groups.
- Increase the availability of doctors at times most convenient to patients.
- Introduce administrative mechanisms within Practices to improve efficiency.
- To improve the collection of activity data to give meaningful information about disease indices and patient care to plan for the most effective use of resources.
- To establish and develop communication systems with all agencies involved with health care.

Incorporated in this is a whole range of new services, some of which command an item of service payment.

Interwoven with the New General Practitioner Contract is the Government's White Paper "Working for Patients" and "Community Care for the next Decade and Beyond".

## "WORKING FOR PATIENTS"

This document, which was made public on the 31st January 1989, had major implications for the future of general practice. Features of it have been incorporated into the new contract; these include medical audit and indicative budgets.

This White Paper introduced the subject of Practice Budgets, later to be known as GP Fund Holding.

## "CARING FOR PEOPLE IN THE COMMUNITY IN THE NEXT DECADE AND BEYOND"

The implications for general practice of this document are that general practitioners and their staff will be expected to be involved in the programme of assessments and the completion of care plans for people living in the community.

## PRACTICE STAFF

In recent years people with new professional skills have been employed in general practice such as:

- Practice Manager.
- Practice Nurse.
- Secretaries.
- Counsellors.
- Paramedics.

Staff reimbursement was introduced in the Doctors Charter of 1966. General practitioners were reimbursed 70% of their staff salaries up to two whole-time equivalents per doctor irrespective of the number of patients on the doctor's list.

## PRESCRIBING IN GENERAL PRACTICE

Prescribing in general practice was virtually unrestricted until 1st April 1985 which the first limited list of medical products was introduced.

PACT emerged in April 1988 and informed general practitioners of their prescribing levels in certain categories of medication - see later.

Prior to that General Practitioners' prescribing was monitored by the Pricing Bureau and only those doctors whose prescribing was in excess of the local average on a regular annual review basis were visited by the Regional Medical Officer who identified "errors of their ways".

*...only those doctors whose prescribing was in excess of the local average on a regular annual review basis were visited by the Regional Medical Officer...*

## 'D' DAY

On the 1st April 1990 the new GP Contract was introduced from which will emerge:

- New style of General Practice managed by:
- New style of management responsible to:
- New style of Family Health Service Authority which in turn will be subject to:
- New style of general management.

*On the 1st April 1990 the new GP Contract was introduced...*


"Nice one! It's a good job I noticed the date!"

Chapter 2

# Practice Organisation and Practice Management

'D' Day was 'Decision Day' for those doctors who were prepared to operate the new contract or leave the National Health Service.

The purpose of this book is to identify:

- The changes that have been introduced into general practice.
- The implications for general practice.
- The changes in general practice management.
- Changes in future funding and the introduction of resource management.
- Projections for the future.
- Indicative budgets.
- GP fund holding.

## CHANGES INTRODUCED INTO GENERAL PRACTICE

"Primary Health Care - An Agenda for Discussion" was published in 1986 and set the first proposals for reviewing the financing of services in general practice. This led to the introduction of a Government White Paper "Promoting Better Health" in 1987 on which the GP Contract 1990 was based. The essential changes introduced included:

- The introduction of new Terms and Conditions of Service for GPs.
- The introduction of health promotion clinics in general practice.
- Introduction of target payments for children's immunisations and cervical cytology.
- Introduction of fees for minor surgery.
- Introduction of fees for child surveillance.
- Introduction of deprivation allowance.
- Introduction of an annual assessment of all patients over the age of 75 years.
- Introduction of a tri-annual review of all patients registered in the Practice, and who have not consulted during the previous three years.
- Introduction of examinations for new registrants.
- Introduction of sessional fees for teaching medical students.
- Introduction of a new scale of fees for night visits.

## IMPLICATIONS FOR GENERAL PRACTICE

The changes in Terms and Conditions of Service required general practitioners to undertake consulting sessions on five days of the week in their practices. There are, however, some exemptions to this whereby a GP can apply to the FHSA General Manager to work only four days a week in his/her practice, the exemption being granted if they are employed in other fields within the health service.

The provision of the extended range of services which are now required in general practice make it essential for the GP to employ other professional support staff to undertake some of the work which has significant cost implications to the Practice.

The new Contract requires GPs to be more accountable and will be subject to medical audit.

Each practice will be required to publish an Annual Report which will include practice activity, staff training and future plans.

## CHANGES IN GENERAL PRACTICE MANAGEMENT

To be successful in achieving the changes in general practice survival will depend on strong management which should be led from the top down and all Practices will need to employ a manager who is responsible for the day-to-day organisation, staff employment and administration and who in turn will be responsible to an identified partner within the Practice.

## INTRODUCTION OF RESOURCE MANAGEMENT

Resource Management was first introduced into the Health Service in the early 1980s and pioneer projects were set up in six hospitals which became known as Resource Management Initiative Centres. These were extended into the community in 1985. There is little doubt that this process will follow into primary care and will be within the remit of the FHSA.

The underlying principles of Resource Management is to identify the services that are funded within an identified budget, evaluate these services and ensure that resources are allocated to where they are most needed and effectively used.

Accurate recording of activity is an essential feature for successful resource management.

## INDICATIVE BUDGETS

Indicative Budgets will be introduced into general practice on the 1st April 1991. Each practice will be allocated

a Drug and Appliance Budget which will be identified by the FHSA and based on the 1989/1990 drug prescribing data.

Practices will have the opportunity to identify to the FHSA any projected overspend due to:

- Changes in practice population.
- New patients whose medical condition requires expensive medication.
- Increase in practice elderly population.

This has introduced a new concept into primary care, that of cash limited budgets, which means practices will be offered a fixed sum of money to be spent within a fixed period of time.

This means that GPs will be expected to keep within their budget and will have to justify to the FHSA any overspend that occurred within the year.

## PROJECTIONS FOR THE FUTURE

The introduction of accountability and medical audit which will be monitored by the FHSA will inevitably lead to an improved standard of primary health care which will have major implications for all those working in this field.

## GP FUND HOLDING

The Government White Paper "Working for Patients" which preceded the GP contract by one month proposed

that practices with a list size of 11000 could be offered a budget. It was subsequently recommended that practices with a list size of 9000 could also be considered for Fund Holding.

At the time of writing budgets are being calculated by the Regional Health Authority based on practice activity. This budget will need to be agreed by the Fund Holding Practices prior to the implementation of the service by the first wave of Fund Holders on the 1st April 1991.

Although primary health care is a demand-led service the ultimate introduction of resource management and the extension of fund holding will require all practices to look to their future organisation.

## RESOURCE MANAGEMENT

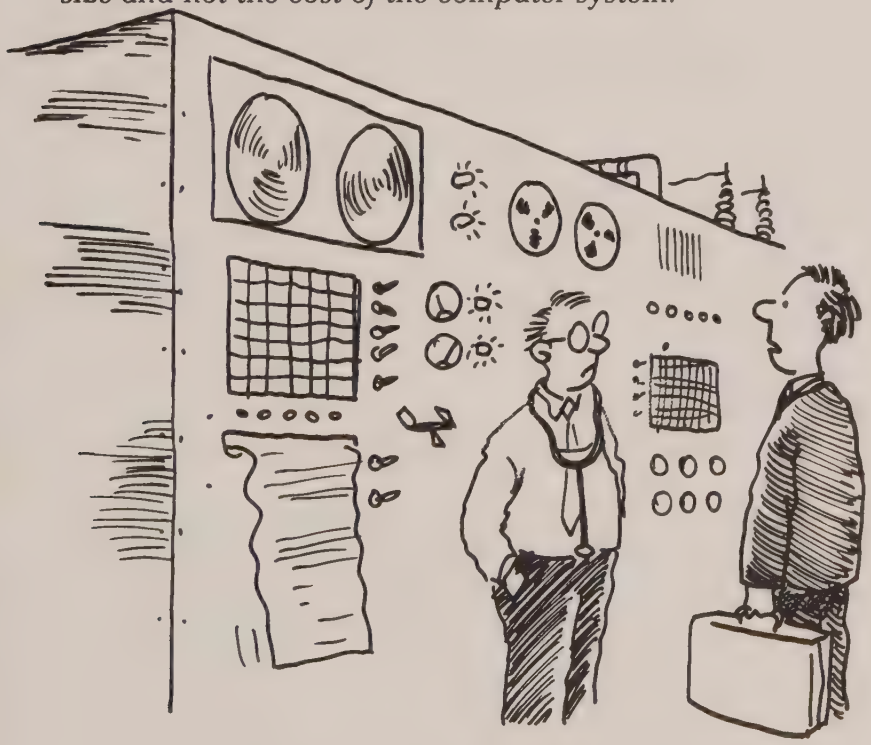
Introduction of Resource Management is inevitable in general practice but the implementation of this concept is impossible without factual information of practice activity, patient referral and subsequent outcome and the general practitioner's use of hospital investigating services.

FHSAs have a remit to identify general practitioner's hospital referral details and practices are currently expected to complete the monthly return to their FHSA, which will provide District Health Authorities information in planning future services in their commissioning role.

## COMPUTERISATION

The introduction of computers into general practice has at last been recognised by the Department of Health and funding has been made available through the RHAs to approve funding for the capital costs and maintenance charges for those practices who have introduced computer systems. A small allowance has been made for staff. Computer reimbursement is related to practice list size and not the cost of the computer system.

*Computer reimbursement is related to Practice list size and not the cost of the computer system.*



"We *were* thinking along the lines of an Amstrad."

## ANNUAL REPORTS

The Annual Reports to be published within three months of the end of the financial year are expected to provide full details of staff and their training, Practice premises, doctors' commitments, prescribing data and practice referral patterns to all specialities identified in the Terms and Conditions of Service, November 1989, Part 1 Appendix 3.

## MEDICAL AUDIT

Introduction of medical audit in general practice will be supervised by the new Medical Audit Committee to be set up by the 1st April 1991 each FHSA and funded by the Department of Health. Medical audit will be operational from the 1st April 1992.

Currently there appear to be no set parameters for medical audit and each Local Audit Committee will establish its own system. The Medical Audit Committee is expected to include representatives from general practice, Royal College of General Practitioners, Director of Public Health and a hospital consultant.

## PRACTICE ORGANISATION - MANAGEMENT

The introduction of the new contract has identified the need for practices to become more sophisticated in their management if they are going to provide an improved service to their patients and meet the demands imposed on them by the Contract.

Successful management depends on good team relationships and the size of the team will be related to the population of the Practice and the activity level the practice wishes to achieve.

The Practice should identify its own Management Board which should include:

- The Partners.
- The Practice Manager.
- The Senior Practice Nurse.
- Representative from the Reception/Clerical Staff.
- Member of the attached Staff or the Location Nurse Manager.
- Chaired by a member of the team.

The Practice Board should follow a written agenda and a nominated secretary should record the minutes of the meetings which should be planned a year in advance.

The Agenda should include :

- The Practice financial position
- A progress report on current issues by individual members of the Board.
- Staffing issues.
- Future plans -

    a) short term.

    b) long term.

Not all members of the Board will be involved in the confidential practice issues such as the Financial Report. The Practice Management Board should allocate tasks to individual members of the Board and it will be their responsibility to ensure that these tasks are completed to a pre-determined timetable.

Example of tasks to be allocated:

- Responsibility for financial management.
- Responsibility for the day-to-day running of the practice.
- Responsibility for implementation of specific issues of the new contract.

Targets:

- Immunisations.
- Cervical smears.
- Child surveillance.
- Elderly screening.
- 3-yearly checks.
- Data collection for Annual Reports.
- Health Promotion Clinics.
- Patient liaison.
- Computerisation.
- Training.

Ideally, management boards should meet on a regular monthly cycle. These meetings should be quite separate from the weekly practice meetings which should be designed to deal with day-to-day Practice issues.

To operate the new GP Contract effectively it is essential for the Practice to be well organised. Effective organisation is a complex matter and will depend on the cohesiveness and strength of the primary care team.

The Primary Care Team consists of:

- General Practitioner(s)
- Practice Manager
- Practice Nurse(s)
- Reception Staff
- Secretary
- Clerical Staff
- Computer Input Clerks
- Attached Staff
- District Nurses
- Health Visitors
- District Midwives
- Community Psychiatric Nurses.

Associated Members of the Team:

- Social Worker.
- Community Rehabilitation Services including:

  Physiotherapy.

  Occupational Therapy.

The Staff employed by the Practice and their organisation will depend on the activity that the Practice wishes to undertake, bearing in mind that all services are not mandatory.

Influences on Practice activity:

- General medical services.
- GP contract.
- Patients' needs.
- Facilities within the practice.
- Staff employed.

General practice provides a general medical primary care service and general practitioners' and their staff's primary function remains that of treating their patients' health needs and maintaining a high quality of care.

Patients' expectations continue to put an increased demand on primary care.

To provide the full spectrum of care that is now expected in general practice, survival will depend on reliable organisation which can only be achieved by effective management.

The organisation of the Practice will be governed by the following factors:

- Day-to-day Management.

  Administrative.

  Clinical.
- Roles of team members.
- Inter-relationships between team members.
- Communication.
- Quality.
- Audit.
- Accommodation available.

## CLINICAL MANAGEMENT

Clinical management is the responsibility of the general practitioner and he/she should decide the details of clinical care that will be provided by the Practice using the Statement of Fees and Allowances ("The Red Book") guidelines.

The role and function of the Practice Nurse needs to be agreed and any extension of that role requires further education, training and assessment, with a Certificate of Competence being issued by the GP working within agreed written and signed practice protocols.

## MANAGEMENT/ADMINISTRATION

Management is best achieved by the employment of a Practice Manager who is responsible for the day-to-day organisation and efficient running of the Practice.
The administrative staff responsible to the Manager include:

- Receptionists.
- Secretary.
- Clerks.
- Data Input personnel.
- Financial Clerk.
- Telephonist.
- Appointment Clerk.

The Practice Manager's other responsibilities include:

- Maintenance of the property.
- Organisation and supervision of cleaning.
- Staff salaries.
- Holiday cover.

- Stock control.
- Equipment maintenance.
- Duty rotas.
- Contracts of Employment including job descriptions.
- Performance review.

It is part of the function of the Practice Manager to identify the roles of administrative staff in the Practice and ensure a close working relationship is maintained between his/her staff and with all the clinical members of the team. It is essential that clearly identified functions are allocated to each member of the staff. These functions should be communicated to all members of the team.

The Practice Manager should also co-ordinate the holiday arrangements for all members of the primary care team so that holiday overlap is avoided and suitable cover arranged.

Co-ordination of the activity of the staff attached to the Practice that are employed by the statutory authorities and voluntary agencies, including District Nurses, Health Visitors, District Midwives, Community Psychiatric Nurses, Social Workers and Voluntary Care Workers, should be arranged between the Practice Manager and the professional manager for each group.

The developments in general practice beyond the contract will require ever-increasing co-operation between community staff employed by District Health Authorities and primary care team members working in general practice. This development must extend to our Local Authority colleagues when Care Managers are established in keeping with the White Paper "Care in the Community".

## COMMUNICATION

Communication is an essential feature of good management and strenuous effort must be made within the Practice to develop good communication links between:

- Members of staff.
- Patients and families.
- Various other staff working in the Practice.

Communication with Statutory and Voluntary Organisations:

- Family Health Service Authority.
- Voluntary organisation.
- Local Authority.
- Health Authority.

Good communication links can be achieved by:

- Practice leaflet.
- Practice notice board.
- Suggestion box.
- Practice interest group.
- Practice newsletter.
- Regular practice staff meetings.
- Clinical meetings.

Regular Practice meetings with appropriate members of statutory and voluntary organisations and Practice staff affords the opportunity to discuss:

- Provision of patient care.
- Identify patient needs.
- Provision of services (who does what).
- Available resources.

## QUALITY

We should be continually aware of the service that we provide in general practice to ensure that the highest level

of quality care is maintained. Quality of patient care can be measured:

- Accessibility of services provided for patients.
- Efficiency of appointment system.
- Length of waiting times to be seen at appointments.
- Flexibility of systems operating within the Practice to suit patient's needs.
- Regular staff performance review.
- Efficiency of communication within Practice, both patient and staff.

## ACCOMMODATION

The developments in general practice in recent years have necessitated ever-increasing requirements for space to accommodate new staff and provide a fuller range of care. The new contract has compounded this requirement and to some extent the space available in the Practice may govern the activity which a practice can undertake.

Developments in primary care for which the Practice need to cater include:

- Treatment room facilities.
- Minor operating theatre.
- Accommodation of 10 people in a health promotion class.

- Facilities for the handicapped.
- Accommodation for computer and input clerks.
- Accommodation for attached staff.
- Accommodation for in-house training and clinical meetings.
- Provision of equipment to provide new services.

## INFORMATION TECHNOLOGY

Practice information is essential for efficient organisation and for monitoring and planning services to patients.

Practice computer systems have only been developed in recent years and are currently undergoing a radical development to cater for the needs of an efficient practice. The Department of Health is currently writing software for the implementation of Indicative Prescribing and for Fund Holding.

Information requirements for monitoring patient activity and completion of annual reports are best achieved through a computer system and the software used to audit the information to complete these programmes.

## Chapter 3

# Practice Organisation - Financial Management

The successful implementation of the new contract will require monumental changes in organisation, management and financial accounting of general practice.

To implement these changes and achieve the high level of quality of care that will be monitored by the introduction of medical audit in April 1992 will require maximum input by all general practitioners and practice managers.

Sound financial systems will need to be introduced in general practice to deal with the current changes and plan ahead for the inevitable introduction of resource management which is currently being introduced into NHS hospitals and community services. Practices will need to introduce a financial manager into their organisation, a task which could be delegated to one of the partners or to the Practice Manager if he/she is trained to accept this enhanced role, or the appointment of a financial officer.

*Practices will need to introduce a financial manager into their organisation...*

"Oh, there's nothing wrong with me, Doctor.
I've come about the position of Financial Manager"

The introduction of an enhanced financial management system within the Practice will not eliminate the need for close co-operation with the Practice Accountant to authenticate the Annual Accounts.

In view of the new systems of payments by FHSAs, e.g. Target payment and Deprivation Allowance, and the increased expenditure Practices will have to undertake to implement the requirements of the New Contract, it will be essential for Practices to know their financial position on a regular basis

and be in a position to produce monthly position statements.

## FINANCIAL PLANNING

Essential features for which all Practices must make appropriate provision are:

- Inland Revenue payments.
- Capital developments.

  Building.

  Equipment.
- Maintenance of property.
- Maintenance of equipment.
- Reserve fund for unplanned expenditure.

## RESERVE FUNDS

An appropriate calculated allowance can be made monthly and secured in an interest-bearing business account to meet the needs identified above.

## STAFF TAX

The Practice is, of course, responsible for staff tax and NIC payments. The appropriate tax is deducted from staff pay and the GP's contribution to staff NIC is fully refundable from the FHSA.

## PARTNERS' TAX:

Responsibility for tax payments will vary with existing practice arrangements:

- The Practice may have a corporate responsibility for the tax of all partners.
- Partners can be sole practitioners and responsible for their own tax payments.

The alternative proposals identified in paragraph 2 above are subject to the agreement of the local Inspector of Taxes and the advantage to individual partners is that they hold no responsibility for their colleague's tax commitments.

## THE EXTRA COSTS IN IMPLEMENTING THE NEW CONTRACT

The extra costs in implementing the New Contract involve all aspects of general practice:

- Clinical.
- Administration.
- Staff.
- Staff Training.
- Capital/Building Equipment.
- Maintenance.

## CLINICAL

Implications for available clinical time in addition to general medical services:

- Examinations for new entrants.
- Examinations for child surveillance.
- Minor surgery procedures.
- Assess and visit patients over the age of 75 years.
- Health promotion clinics.
- Examination of patients not seen in Practice for three years.
- Achieving targets for child immunisations and cervical cytology.

All these services will require general practitioners to spend more time on clinical care. The mandatory services are:

- Examination of new entrants.
- Assessing the elderly (75 years and over).
- Three yearly checks.

Regular training up-dates to be recognised for providing specific services, e.g. child surveillance.

Postgraduate training in:

- Disease management.
- Health promotion.
- General management.

## ADMINISTRATION

All the new services in the contract have major administrative cost implications for the Practice. Some of these services attract an extra fee, others do not.

**Those that attract NO fee**

- Practice leaflet, the aim of which is to provide practice information about doctors, staff and service provision and is to be made available to all patients within the Practice and must be updated each year.
- The day-to-day collection of practice activity to be incorporated into an Annual Report.
- The requirement to write to all patients not seen in the Practice for three years and invite to attend for examination.
- The monitoring of elderly patients over the age of 75 years and inviting them to attend for health screening and offering a home visit.

**Those that attract a fee:**

- Invitation for new registrants of the Practice to attend for health screening. Patients are specifically to be invited by letter within one month of joining the Practice.

- Target payments

  (a) Immunisations:

  Inviting new babies and children under the age of five years to attend Child Health Clinics to maintain their immunisation status.

  (b) Cervical cytology:

  Maintaining an accurate register of all women for whom a cervical smear should be undertaken every three years, although target payments are made for the cohort 25 - 64 years on a five and half year cycle (Scotland 20 - 60 years).

- Child surveillance

  The maintaining of an accurate register of all children 0 - 5 years for the implementation of the child surveillance programme.

- Health promotion

  The introduction of Health Promotion Clinics the aim of which is to promote a healthy lifestyle.

  The early detection of diseases and their prevention.

Health promotion has financial rewards for those Practices that provide this service. Each FHSA has been asked to approve programmes of health promotion, the guidelines for which have been issued by the Department of Health.

Health Promotion Clinics can include:

- Well Person.
- Management of disease including Diabetes, Asthma and Cardiovascular.
- Obesity.
- Alcohol.
- Anti-Smoking.

Each Health Promotion Clinic is expected to include at least 10 people.

- Minor surgery

The undertaking of minor operations by all doctors approved by their FHSA.

For surgical procedures which attract payment see Appendix 6 in Part 1 of this series.

Each FHSA has established its own criteria for GP's recognition to undertake.

- Child surveillance
- Minor operations.

**Postgraduate Training**

It is mandatory for general practitioners to undertake 10 full sessions per year on

Postgraduate Training to be divided equally over a three year programme on:

(a) Disease management.

(b) Health promotion.

(c) General management.

## PRACTICE INCOME

The 1990 Contract which identified the change in GPs' Terms of Service also contained major recommendations with regard to remuneration.

The following payments were withdrawn: (Fees 1989/90)

- Group Practice Allowance - £1600 per annum
- Supplementary Practice Allowance - £1860 per annum with up to 100 patients; £1.65 per patient for 100 - 199 patients
- Supplementary Capitation Fees £1.85 per patient with over 1000 patients
- Postgraduate Training Allowance - £828
- Vocational Training Allowance - £1840
- Item of Service Payments

Cervical Cytology - £8.90 per test.

Children's Immunisations

A - £3.05 per patient.

B - £4.45 per patient.

There was a variation introduced in the payments of:

- Basic Practice Allowance.
- Night Visit Fees.
- Seniority payments.

The fees saved by the withdrawal of these Allowances will be re-deployed to fund the introduction of new schemes which makes them to a large extent self-financing.

The following fees have been introduced and the calculations are based on payments as of 1st January, 1991 and quoted annually:

## BASIC PRACTICE ALLOWANCE

Basic Practice Allowance which will be payable in respect of the first 1200 patients of a GP's list and will not be paid to GP's with fewer than 400 patients on their List.

The maximum fee payable for 1200 patients is £6000 per annum.

First 400 patients £2500 per annum.

Further Payments:

| | |
|---|---|
| 401-600 | £6.25 per patient per annum. |
| 601-800 | £5.00 per patient per annum. |
| 801-1000 | £3.75 per patient per annum. |
| 1000-1200 | £3.50 per patient per annum. |

Maximum Payments

| | |
|---|---|
| Half-time general practitioner | £3750 |
| Three-quarter time general practitioner | £5125 |

## INTRODUCTION OF DEPRIVATION PAYMENTS BASED ON THE JARMAN INDEX

Jarman table of Categories of Payment

| | | |
|---|---|---|
| 1. Lower Rate | 30-39.9 | £5.05 per patient per annum |
| 2. Middle Rate | 40-49.9 | £6.65 per patient per annum |
| 3. Higher Rate | 50+ | £8.80 per patient per annum |

## CAPITATION FEES

Capitation fees are still weighted for age:

| | |
|---|---|
| Under 65 years | £12.40 per patient per annum |
| 65-74 years | £16.30 per patient per annum |
| 75+ years | £31.45 per patient per annum |

## CAPITATION FEE FOR CHILD SURVEILLANCE

This fee has been introduced and applies to children under the age of five years who are registered with the practice for child surveillance.

Child surveillance fees are payable to doctors who have been approved by their FHSA at the rate of £5 per child per annum.

## NEWLY REGISTERED PATIENTS

A fee will be payable to general practitioners who complete a health screen on patients over five years of age within three months of them joining the list. New Patients must be invited by letter within a month of joining the Practice to attend for Health Screening.

Claims for Registration fees can be submitted within twelve months but the FHSA will require an explanation for the delay in completing the examination.

*...the FHSA will require an explanation for the delay in completing the examination.*


"It appears the patient hasn't been able to attend the surgery because she hasn't been well."

A fee of £5.80 is payable for all newly registered patients who have completed a health screen on joining the Practice.

## POSTGRADUATE EDUCATION ALLOWANCE

Full Rate £2025 per annum.

The fees for this service are to replace:

a) Vocational Training Allowance for doctors.

b) "Top Sliced" from the seniority allowance for those doctors entitled to this payment.

Postgraduate education courses are recognised for groups of not less than 10 doctors and recognition of the course need to be made by the Postgraduate Education Dean.

Courses can be undertaken by local groups of GPs' who have arranged the required programme for recognition.

Fees are, however, paid for various levels of attendance during the course of the year and relate to the number of sessions completed.

**Minor Surgery Fees**

Minor Surgery fees have been introduced and individual general practitioners can claim a maximum of three payments per quarter having averaged 5 surgical procedures per month in that quarter.

Fees Payable: £100 per session.

A maximum of three Sessions per quarter: £300.

Annual Fees: £1200.

## HEALTH PROMOTION CLINICS

Health Promotion Clinics command a sessional fee of £45.00, which requires the attendance of 10 patients at each clinic which may be undertaken by the appropriate health professional.

Proposed Health Promotion Clinics have to be approved by the FHSA.

All proposed Health Promotion Clinics should have an agreed protocol to which all members of the Primary Health Care Team who are involved in each clinic follow.

Some of these clinics require a one-to-one consultation and to achieve the required number of attendances per clinic will require a significant amount of time.

## OUT-OF-HOURS SERVICES

The period of out-of-hours services has been extended from 10p.m. to 8a.m. the following morning.

A payment differential of 3 - 1 is paid to those doctors:

- Who undertake their own out-of-hours calls.
- Form part of a non-commercial rota of no more than ten doctors.

Fees paid to this Group £45.00 per call.

General practitioners can continue to use a commercial deputising service. Out-of-hours services for the Group will be funded at £15.00 per call

## TEACHING MEDICAL STUDENTS

A fee has been introduced for the teaching of undergraduate medical students, the aim of which is to give them experience in general practice.

A fee may be claimed for each student for each session to which the student is attached to the Practice, which will include time spent in education or training in the provision of general medical services undertaken by any member of the Practice team.

No more than two sessions per student can be claimed in any one day.

## TARGET PAYMENTS

Target payments have been introduced to replace Item of Service payments for:

- Child Immunisations.
- Cervical Cytology.

## IMMUNISATION TARGETS

Payments are made by achieving the following targets 90% and 70% and the differential payment for achieving these targets is 3-1.

Immunisations include:

- Children under the age of 2 years.
- Pre-School Boosters for Children under the age of 5 years.

Immunisations must form part of general medical services and to qualify for target payments the immunisation must be undertaken as part of this service.

The doctor who qualifies for payment is the one who completes the immunisation course irrespective of which practitioner gave the first injections. The credit will be with the doctor with whom the child is registered.

Immunisations for children under the age of 2 years are in three groups:

| | | |
|---|---|---|
| Group 1 | DTP - | 3 doses |
| Group 2 | Pertussis - | 3 doses |
| Group 3 | Measles/MMR - | 1 dose |

**Pre-school Boosters**

Pre-school boosters comprise a single group of diptheria, tetanus and polio to be given by the age of 5 years.

The calculations to identify the required target level are complex as are the calculations for payment where all the services have not been undertaken within the Practice.

Immunisations undertaken elsewhere, other than part of general medical services, can be included in the calculation for targets but cannot be included towards target payments.

If the lower targets are not reached the Practitioner will not qualify for any payment.

Target payments for average list for immunisations are:

Childhood Immunisations:

| | | |
|---|---|---|
| Higher | - 90% | £1800 |
| Lower | - 70% | £600 |

Pre-School Boosters:

| | | |
|---|---|---|
| Higher | 90% | £600 |
| Lower | 70% | £200 |

## CERVICAL CYTOLOGY

Payments are made by achieving the following targets:

80% - 50% and the differential payment for achieving these targets is 3 - 1

Target Payments for average list

| | | |
|---|---|---|
| Higher | 80% | £2280 |
| Lower | 50% | £760 |

The cohort of women upon which cervical cytology targets are based is between the ages of 25 - 64 in England and 20 - 60 years in Scotland, which comprises an average of 27% of the population. A satisfactory smear has to be achieved within the previous five and half years and undertaken as part of general medical services within the Practice.

The level of achievement is calculated after the removal of all those women who have had a total hysterectomy.

Cervical smears undertaken outside the Practice can be included in the target calculation but cannot be included in the payment.

The maximum payment can be calculated as follows:

$$\left(\frac{\text{Total eligible women on list}}{\text{Number of eligible women on average list}}\right) \times \left(\text{Maximum amount payable to the doctor with the average list}\right)$$

**Example:**
Number of women 25 - 64 on list = 800
Number of women 25 - 64 on average list = 550
Payment scale = 80% or 50%
Sum payable- X the amount payable to the Doctor with the average list 550 Average list.

To achieve maximum payment a target of 80% of the required cohort has to be reached. The remaining 20% will include all those women for whom it is inadvisable to take a smear, the non-sexually active and those patients who refuse.

It is recommended in many authorities that all sexually active women should be given a smear on a three yearly cycle.

A cohort of sexually active women between the ages of 16 and 24 will comprise 7% of the population.

5% of all smears taken are reported as inadequate and need to be repeated.

20% of all smears need to be repeated for clinical reasons.

Claims for target payments for immunisations and cervical cytology have to be completed on the computer print-out provided by the FHSA.

## GENERAL MEDICAL SERVICES

General practitioners are private contractors to the NHS and are contracted to undertake the provision of general medical services for a minimum of 26 hours per week, and those extra services which have become mandatory in the new contract:

- Health screening for new entrants.
- Assessment of patients over the age of 75 years and offer of a home visit.
- Inviting patients not seen for three years for a health screen and informing FHSA if they have moved from the district.

## SUPPLEMENTARY INCOME

General practitioners are not precluded from undertaking paid sessional work within or outside the NHS. This can include:

- Hospital Practitioner sessions.
- Clinical Assistant sessions.

- Visiting Medical Officer.
- Medical sessions in the prison service.
- Clinical sessions including Family Planning and Child Health.

Management appointments include:

- Regional Health Authority.
- District Health Authority.
- FHSA.
- Police Doctor.

Private Organisation:

- Factory Doctor
- Occupational Health

## OTHER FEES

General Practitioners can earn fees by issuing:

- Private Medical Certification.
- Private Medical Reports on their patients.

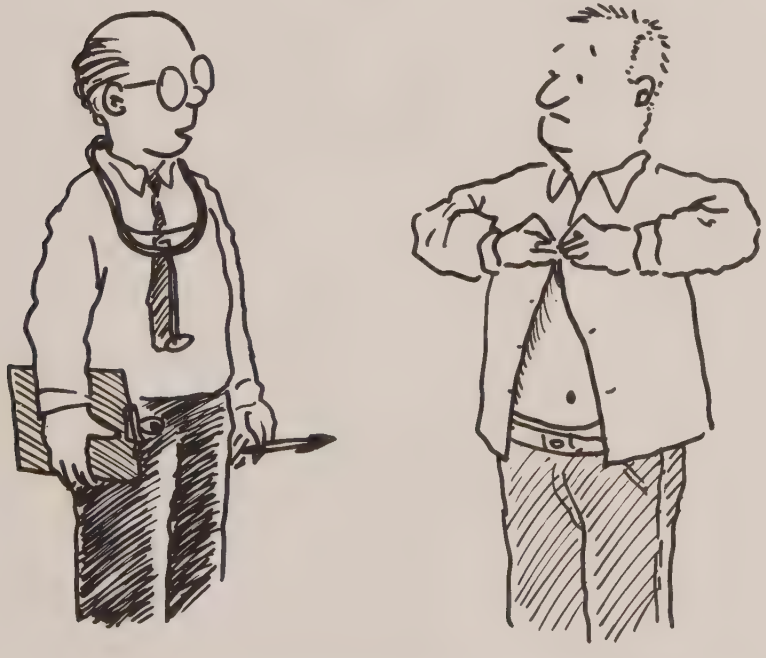
Fees for completing documents from Medical Examinations on their patients for a variety of services including:
examination for:

- Heavy Goods Vehicle
- Taxi Driver

- Elderly Driving Licence
- Deep Sea Diving
- Fees for attending Court
- Fees for attending Case Conference

All these extra services that are expected of a General Practitioner, although commanding a fee, are time-consuming and an added burden in the provision of a full and comprehensive service to all patients.

*...including...examination for...taxi driver*



"Physically, you're in good shape to be a taxi-driver - but I'm rather concerned about your paranoia of people talking behind your back."

Chapter 4

# Practice Development

The extension of primary care, the requirements of the New Contract and the mechanisms that will need to be employed to operate the New Contract will require additional facilities for the practice.

The developments in primary care for which the Practice needs to plan include the extra administrative costs to implement and operate the New Contract:

- Staff.
- Stationery.
- Postage.
- Disposables.
- Clinical waste disposal.

## STAFF

- Extra clinical time by the partners.
- Employment of special support staff, e.g. Nurses, Counsellors.

- Secretarial time.
- Clerical time.

## STAFF TRAINING

Staff training is required by all staff to achieve management of change:

- New patient services.
- New basis of remuneration.
- Collection of data and its analysis.
- New range of FHSA forms to be completed.

Practices need to identify the required training programmes and allocate the funding.

## CAPITAL

The new services will require facilities in which to operate this extra provision:

- Accommodating patients for health promotion clinics.
- Minor operation surgery (treatment room).
- Treatment room for practice nurse.
- Computer room.

It is probable that to achieve the full range of services structural changes will need to be made or extension to premises be considered. This can be undertaken by Cost Rent Schemes.

*...that to achieve the full range of services structural changes will need to be made or extension to premises be considered*


"There you go, guv - you'll be able to get the full range of services in that....weddings, baptisms - you name it!"

## COST RENT SCHEMES

These schemes are now the responsibility of the FHSA and the funding is cash limited by an agreed budget set prior to the beginning of the financial year. Details of Cost Rent Schemes are included in the 'Red Book' - Statement of Fees and Allowances 51. 50-57.

The building cost limits are related to the number of doctors working within the Practice and there now exist four cost rent limit bands which are reviewed each year.

Practices wishing to extend or rebuild their premises must obtain prior approval from their FHSA to ensure the availability of the cost rent within their cash limited budget.

New buildings and extension to premises will also need to be approved by the FHSA Medical Adviser.

The Finance Act of 1989 has introduced a VAT charge on the development of new buildings and all GPs extending or rebuilding their premises will probably be subject to VAT.

## EQUIPMENT

Appropriate equipment is an essential requirement to provide the specialist services in the Contract. These include:

- Sterilising equipment for minor operations - an autoclave which is approved and meets the requirements laid down by the Department of Health.

- Surgical equipment.
- Sterile packs.
- Protective clothing.

For child development work the following will be required:

- Standard centile charts to plot weight and head circumference.
- Scales.
- Baby measuring tape (paedometer), wall chart.
- Torch, Ophthalmoscope.
- Stethoscope.
- Red brick/ball.
- Child's table and chairs to sit at.
- Stycar vision and hearing box .

## MAINTENANCE

The extension of services to patients, the increased use of facilities and the possible development or extension of premises will have maintenance implications in the following areas:-

- Building.
- Heat and light.
- Cleaning.

- Service contracts for equipment.
- Clinical waste disposal services.

## COMPUTERISATION

The requirements of the new contract and the future organisation in the management of general practice highlights the need for all practices to be computerised if they are to be successful in:

- Providing services identified in the new contract.
- Having available information for planning new services.
- Providing an efficient record of practice prescribing.
- A Practice disease index.
- Providing information to the FHSA and the District Health Authority on Practice referral patterns.

Computerisation of the Practice has major cost implications in the following areas:

- Capital.
- Maintenance.
- Staffing.

## CAPITAL

There are several computer companies which market systems to provide a full range of software appropriate to general practice.

Computer systems can be purchased or acquired through a lease arrangement.

The Department of Health now part refund the capital outlay for installing, upgrading, and maintaining computer systems. The funds available are related to practice size.

## MAINTENANCE

All computer companies offer a support service for their computers in Practice which is an essential requirement to operate an efficient system.

The response time for maintenance calls is an important feature of a maintenance contract.

The Department of Health part fund maintenance fees which are related to the list size.

## STAFF

All computer systems are only as reliable as the data put into the system and it is essential that a high degree of accurate recording is established to provide reliable information.

It is advisable that all practice personnel should be trained to use the computer system.

Data recording, however, can be undertaken centrally by the employment of computer input clerks whose exclusive role should be entering and up-dating computer information. An alternative method of recording data is opportunistically by members of the Practice team who will need to have their own VDU in the consulting room and office.

The New Contract has led to a revolution in the operation of Practices and there appears to be no guidance as to how this should be implemented, each Practice being required to develop and operate its own systems.

Training is required by all Practice members of the primary care team to understand and implement the changing role of general practice to fullfil the implications of the new contract.

- FHSAs are in the process of establishing training courses for practice staff.
- Clinical tutors are establishing postgraduate education programmes for GPs.
- Practice nurse training courses are available in various recognised centres.

Chapter 5

# General Practice Fund Holding

The Government White Paper "Working for Patients" published in January 1989 introduced the concept of General Practitioners managing their own budget for specifically identified services. This was subsequently called GP Fund Holding.

Fund Holding Practices will undertake the role of commissioners of services for their own patients in a similar way to that of District Health Authorities who will commission services for their resident population, excluding the GP Fund Holding patients.

Applications for Fund Holding were open to all practices with a combined List of 9000 or more and those who applied had to be assessed by their FHSA Manager to confirm:

- The Practice had the ability to manage a budget.
- The Practice employed the appropriate staff to operate the budget.
- Practices were fully computerised and would be able to operate the fund holding software.

The Government's philosophy of this introduction was based on the principle that General Practitioners were uniquely placed to make it possible to:

- Give patients wider choice of referrals to hospital.
- Improve the quality of services.
- Give general practitioners a greater control over service provision.
- Encourage GPs to develop services within their Practices where appropriate.
- Review all patients attending hospital out-patients.
- Make careful analysis of practice activity and audit.
- Develop skills in finance management for GPs and their staff.

## WIDER CHOICE OF REFERRALS TO HOSPITALS

GP Fund Holders will be able to refer any patient to any centre within the NHS or private sector for any consultation, investigation or treatment which is covered by the Fund Holding Budget.

General practitioners or members of their team are expected to negotiate contracts with any centre to whom they refer their patients and there will be no restriction of funding these services from the budget and the general practitioner will be responsible only for the first £5000 of any treatment programme. Costs in excess of this amount will be reimbursed by the patient's district of residence.

## IMPROVE THE QUALITY OF SERVICES

GP Fund Holders will be able to influence the quality of care offered by hospitals by identifying quality issues in their Contract which the hospitals or other centres will be required to fulfil thus introducing an aspect of competition by providers to meet the service requirement of patients.

*...thus introducing an aspect of competition by providers to meet the service requirement of patients...*


"How many beds have we got? Is that water beds or four-posters?"

## GREATER CONTROL OVER THEIR SERVICE PROVISION

GP Fund Holders will be able to identify the services provided to their patients within their contracts which can include:

- Frequency of attendance.
- Length of stay of patient.
- Tertiary referrals.

These issues can ultimately lead to reduction in waiting times for patients to be seen or admitted.

## ENCOURAGE GPS TO DEVELOP SERVICES IN PRACTICE

The GP Fund Holding system will encourage GPs to develop in-house investigation procedures, e.g.:

- Blood Lipids.
- Blood Glucose.
- Hb.
- ESR.
- Pregnancy Testing.
- ECGs.

This will require GPs to establish a quality control mechanism.

**Direct Access Services**

- Speech Therapy.
- Physiotherapy.
- Audiology.
- Occupational Therapy.

**Specialist Consultations**

These can be undertaken at the Surgery by private arrangement with consultants which can be funded from the budget.

## REVIEW OF PATIENTS ATTENDING HOSPITAL OUT-PATIENTS

GP Fund Holders will be responsible for initial and continuing out-patient consultations which will create an incentive to review all patients attending for hospital follow-up and encourage the patient's discharge where appropriate.

## ACTIVITY ANALYSIS AND AUDIT

GP Fund Holders will be required to determine the practice activity before they are in a position to accept a base-

line budget which will be offered by the Regional Health Authority.

To achieve this GP Fund Holders will need to analyse their referral data for all services which will be based on Patient Consultations. This analysis will lead to in-house audit and the establishment of quality measures of all services provided by doctors and their colleagues within the Practice.

## FINANCIAL MANAGEMENT

The financial reports required by the RHA from Fund Holding Practices are very complex and computer software has been developed by several companies to meet these requirements. The data inputting and interpretation of the reports resulting from this process will require special skills for which training will be arranged with the software manufacturers. This will lead to an improved financial performance within the Practice.

## THE PRACTICE FUND

The fund offered to Practices will cover:

- Clinical, direct referral services and investigations which will be funded by the RHA and this will be "top sliced" from the appropriate DHA.
- 70% staff reimbursement for which the Practice is actually funded by the FHSA.
- Indicative prescribing budget funded by the FHSA.

## VIREMENT

The GP Fund Holding budget will be cash limited and the Practice will have to keep within the overall agreed budget funded from the RHA and the FHSA. Fund Holders can exercise virement within their budget which will allow them to vary the expenditure on the different sub-heads, e.g. savings on prescribing costs can be transferred to expenditure on hospital services. The maximum cost to contract for the provision of treatment any patient in one year is limited to £5000.

## HOSPITAL SERVICES

The GP Fund Holders will be expected to provide the following hospital services from their allocated budget:

**Included in Fund :**

- Almost all OPD services including investigations
- DV arranged by GP.
- Direct referral services:

  Physiotherapy.

  Speech Therapy.

  Occupational Therapy.

  Audiology.
- Screening.

  Cervical Smears.

  Mammography.

- Continuing OP Treatment.

  Resulting from referral prior to 1.4.1991.

- 2nd and Subsequent OP.

  Resulting from in-patient stay not covered by fund.

- Antenatal blood tests.
- Pregnancy tests.
- Consultant referrals to direct access services subsequent to referral by GP .
- Consultant Psychiatrist - wherever consults.
- Referrals by practice staff e.g. practice nurse.
- Ward Attender not requiring bed requiring further care following IP stay.

**Excluded :**

- OP treatment following in-patient (stay) treatment started before 1.4.1991.
- Self referrals e.g. Well Woman, Day Unit.
- A/E.
- Maternity services including postnatal.
- Hearing aids.
- National call and recall for cervical smears and mammography and any subsequent tests resulting from Call/Recall.

- First OP appointment resulting from in-patient stay - not covered by Fund.
- Neonatal care.
- Dietetics.
- Orthoptic.
- All community services except direct referral.
- CPN and clinical psychiatrist.
- Consultant referral to the CHS arising from GP referral to consultant.
- Referral to mental health team.
- Child Guidance clinics.
- Services of LA (SS., Education).
- Referral by attached staff, e.g. HV.
- STD.
- Chemotherapy.
- Radiotherapy (even resulting from in-patient care).
- Emergency admission.
- Non-attenders at OPD.
- Day care.
- Ward Attenders using hospital bed.
- Termination of pregnancy.
- Renal dialysis - OPD/in-patient.

## CONTRACTS

Fund Holding Practices will be required to negotiate a ontract with all hospitals (Providers) to whom they send their patients for any services covered by the fund.

**Contracts can be:**

- Block Contract

  where the GP Fund Holder pays an annual fee to a hospital for a defined range of services

- Cost and Volume

  when the GP Fund Holder will pay a hospital agreed fees for the treatment of an arranged number of cases

- Cost per Case Contract

  where the GP Fund Holder agrees the fees on an individual patient basis.

**Contracts should also include quality issues, e.g.:**

- Waiting time to be seen in the clinic.
- Waiting time for an appointment.
- Waiting time for admission.
- Standards of care within the hospital.
- Informing the Fund Holders of:

  Appointment.

  Outcomes.

## REPORTS

Monthly reports need to be submitted to the FHSA and the RHA.

The following are the activity reports that will need to be produced on a monthly basis:

- Analysis of Block Contract referrals.
- Referral Exception Report.
- Hospital service accruals.
- Claim for treatment costs over 5000.
- Patient referral costs audit trial.
- Analysis of referral costs by treatment type.
- Analysis of treatment by hospital and analysis of treatments summary.
- Current and future year commitments.

Practices will be required to establish a special Fund Holding account for any monies paid to them by the FHSA. All accounts will be handled by the FHSA and will only be paid to the providers by the agreement of the Fund Holder.

Discrepancies between Fund Holder and Provider will be arbitrated by the RHA.

Under-spent funds from within the budget will, at the end of each financial year, be transferred to a reserve account

and can be spent by the Fund Holder in improving their Practice.

These reserve funds can only be spent on areas or items of improvement yet to be identified by the Department of Health.

The Fund Holding budget will need to be audited within one month of each financial year and is subject to review by the Audit Commission.

Chapter 6

# Re-Organisation of the National Health Service

The Government White Paper "Working for Patients" proposed a re-organisation of the NHS which is due to be implemented on the 1st April 1991. The principal changes that will occur are:

- District Health Authorities will be responsible for their resident population as opposed to a catchment population.
- District Health Authorities and Fund Holding Practices will commission a complete range of services for their patients.
- Providers, which include hospital and community units, will bid for the services which commissioning authorities are seeking for their residents.
- The establishment of NHS Trusts responsible to the NHS Trust Board.
- District Health Authorities were re-organised in the Autumn of 1990 and their membership reduced to five non-executive members appointed by the Regional Health Authority and the Chairman appointed by the Secretary of State and five executive members.

- Non-executive members of the Authority are now paid for their services £5000 per year and expected to contribute a minimum number of days per year for their work with the DHAs.

- The establishment of Family Health Service Authorities on the 19th September 1990 to replace Family Practitioner Committees.

## COMMISSIONING

District Health Authorities have set up commissioning organisations who are currently responsible to DHAs and their remit is:

- To determine total health provision required by their resident population in all aspects of care.

- To establish and negotiate contracts with provider units who are able to provide the level of care required by the commissioners at an agreed price. Contracts, or service agreements, will need to be agreed by both parties and include quality measures which each provider unit will need to fulfill.

- Commissioning Authorities are required to consult with the local GPs about the range of services that it proposes to commission, and from which provider units.

## PROVIDERS

Providers include hospital and community services which will comprise existing units of management in a district.

Unless these provider units have trust status they will be directly managed by their District Health Authority.

## NATIONAL HEALTH SERVICE TRUSTS

The first wave have been approved by the Secretary of State. Trusts remain within the Health Service and responsible to the National Health Service Trust Board and no longer responsible to District or Regional Health Authorities.

National Health Service Trust status will afford units a measure of freedom and independence from existing negotiated National agreements and give them some measure of control of their capital assets.

## GENERAL MEDICAL SERVICES COMMITTEE

The General Medical Services Committee is the General Practitioners' National Body which negotiates with the Secretary of State and the Department of Health on all matters related to General Practice including Terms and Conditions of Service. The GMSC was responsible for negotiating the recent GP Contract.

Membership of the GMSC is nominated and elected by GPs.

## LOCAL MEDICAL COMMITTEE

Local Medical Committees represent their local practitioners who are elected by them. The Committee appoints its

own Chairperson. The function of the Local Medical Committee is to represent all the GPs in their District and negotiate with local hospitals and statutory bodies any issues that concern the operation of general practice and the local provision of primary, secondary and community care.

## RESPONSIBILITIES OF LOCAL MEDICAL COMMITTEES

- Local Medical Committees can initiate research into general practice and support their colleagues in an advisory role on patient care by establishing agreed protocols in consultation with colleagues.
- Advise and support their colleagues in service committee cases.
- Nominate GPs onto local National Health working parties and research groups in order to represent the interests of GPs.
- Represent their colleagues in discussions with the FHSA on implementing the Contract. Some Authorities have set up GP advisory groups to discuss the complexities of the new GP contract.
- Advise on planning issues for the development of primary care.
- Keep their colleagues informed of changes within the Health Service and the significances of these changes with regard to patient care.
- Nominate doctors to the Regional Health Authority for the appointment of the GP representative on the FHSA.

*...some Authorities have set up GP advisory groups to discuss the complexities of the new GP contract...*

"This is the group who will advise you on the complexities of the Contract, but they want to know have you got anything for a bad headache?

- Nominate membership of the new Medical Audit Committees which the FHSAs had to establish by the 1st April 1991.

- Encourage a closer working relationship with Consultants and Health Authority Managers.

## THE FAMILY HEALTH SERVICE AUTHORITY

This new Authority was established on the 17th September 1990 and is designed to replace the Family Practitioner Committee which was formed in 1974 at the time of the first National Health Service re-organisation. The FPC in turn had replaced the Executive Councils who were re-

sponsible for managing Primary Care Services at the onset of the National Health Service in 1948.

FHSAs are now responsible to Regional Health Authorities.

The FHSA's Chairperson has been appointed by the Secretary of State and the membership has been limited to nine members nominated by the Regional Health Authority and the General Manager.

The new Authority has the following membership:

- Chairperson appointed by the Secretary of State
- Five lay members nominated by the Regional Health Authority
- Four professional members:

  A general practitioner.

  A dental surgeon.

  A pharmacist.

  A nurse with community nursing experience.

  - all nominated by the Regional Health Authority.
- General Manager of the FHSA who will be a full member of the Authority.
- 5 Executive members appointed by the Board.

This new structure is a vast change from the previous FPC membership which included a broader representation from both professional and lay members, and consisted of 31 members.

The new Authority will have a broader role in planning and developing primary care services and in the future may have a wider responsibility for health care provision.

The Authorities will retain their responsibility for the provision of Service Committees and to achieve all these functions with a small membership will undoubtedly require a major commitment from members.

FHSAs may find they need to co-opt professional and lay members to achieve their function.

# Appendix 1

**Monthly Income Accounts - Sources of income:**

- Fees paid by FPC
- FPC refund staff salaries
- Payment drugs/appliances
- Cost rent or rent refund
- Rate refund
- L.A. notification fees
- Insurance fees
- Private fees
- Miscellaneous income

**Monthly Expenditure Accounts - Transactions**

- Staff salaries income tax
- General expenses / petty cash
- Printing and stationery
- Drugs and dressings
- Telephone and radiopaging

- Heat and light
- Repairs and decorations
- New equipment
- Equipment service contracts
- Locum fees
- Rates / interest / insurance
- Transfers to capital or deposit A/C
- Partners

# Appendix 2

## PRACTICE NURSE'S WEEKLY DIARY SHEET HEADINGS

### General Nursing

- Dressings
- Sutures
- Holiday vaccinations
- Children's immunisations
- Ear syringing
- Injections: Tetanus
  Rubella

### Health Promotion Screening

- New patients
- Well person
- Stop smoking
- Asthma
- Diabetic
- Diet / exercise
- Cardio-vascular

- Elderly
- MRC TPT
- Family planning
- Pregnancy health promotion
- Counselling / advice

**Investigations, Procedures, Others**

- Blood tests
- Swabs
- Minor operations
- Cryo-cautery
- Polio-oral
- 'Flu

**Practice Management Compendium**

Part 1: Understanding the Contract
Part 2: Organising the Practice
Part 3: Finance and Reports
Part 4: Clinical Practices

Here in a single set of volumes is up-to-date and practical advice on the major aspects of practice management for the 1990s and beyond.
The introduction of the new Contract and Terms of Service for General Practitioners will have an often dramatic effect on the way that individual practitioners work as well as on how practices are organised.
Each of the four volumes of the Compendium looks at a major area of practice life in the light of new legislation. Key points are highlighted and concisely explained in terms of their relevance to the General Practitioner and to the practice as a whole.

Part 4- "Clinical Practices" is divided logically along the lines of the Contract and concentrates on the more clinical aspects and how they may be organised: maternity and child care; cervical cytology and family planning; check-ups; over-75s; health promotion clinics; minor surgery; audits - checks - protocols.
For each section: What is intended and why? Who to do it and why, where and when?

The other volumes in the Compendium are:

Part 1: Understanding the Contract
Part 2: Organising the Practice
Part 3: Finance and Reports

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